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"I just can't sit around and do nothing!"
Experiences of women diagnosed with, and treated for, heart disease in Indonesia: a qualitative study

Abstract

Cardiovascular disease is currently responsible for 37% of the total deaths in Indonesia. Research into cardiovascular disease and its management in Indonesia has heavily emphasized biomedical aspects of the disease; little is known about the individual's experience of the disease, especially the experiences of Indonesian women. The aim of this study is to understand how gender shapes Indonesian women's experiences of living with heart disease and how it affects their daily lives. A qualitative research design was employed, which was informed by intersectional approaches to gender and culture. A total of 26 women aged between 30 and 67 years were interviewed. Transcribed interview data was analyzed using a qualitative framework analysis. Three major themes were inferred from the data analysis: 1) the effect of CVD on women's day-to-day activities, 2) the effects on women's family relationships, and 3) women's coping strategies. The inability to fulfill the required social roles as a mother or a wife undermined the women's sense of self. This problem was particularly evident in Indonesia's cultural context, where maintaining harmony in the home and society is ascribed to women. Healthcare professionals should be aware of the ethnic and cultural backgrounds of women with cardiovascular disease, in order for those professionals to deliver services that meet the social, spiritual, and cultural needs of their female patients.

Keywords: cardiovascular disease, experience, feminist, gender roles, qualitative research, women

1. Introduction

Cardiovascular disease (CVD) is the leading cause of death for women globally (World Health Organisation, 2014). The Centers for Disease Control and Prevention (CDC, 2020) estimates that one in five deaths of women in the USA is from CVD. In Indonesia, for the last decade, ischemic heart disease (IHD) and stroke have been identified as the leading causes of premature deaths among both men and women (Mboi et al., 2018). Data from the Global Burden of Disease study (2016) indicated a 14.2% increase in deaths due to IHD in Indonesia from 2005 to 2016 (Mboi et al., 2018). According to the Indonesian Heart Association report, the proportion of women referred to the National Cardiovascular Center in Indonesia, due to acute coronary syndrome, was as high as 22.4% of the total patients (PERKI, 2015). Women's mortality rates in the nation's hospitals were 70% higher than for men (10.6% v. 6%).

Although heart disease has traditionally seen as "a man's disease" (Emslie, 2005; Galick et al., 2015), it is increasingly understood to be a health problem for women as well. This traditional male-oriented belief has meant that women with CVD have been overlooked globally (Lockyer & Bury, 2002). Previous studies into women's recovery from heart disease have shown that women experienced feelings of guilt and shame (Svedlund et al., 2001), insecurity, and uncertainty about life and death (Burström et al., 2012; Johansson et al., 2003). Changes in family roles and/or relationships (Galick et al., 2015; Smith et al., 2017) contributed to those female patients' fear and anxiety for the future (Sjöström-Strand et al., 2011). A meta-synthesis of women's experiences of recovery after Myocardial Infarction (MI) (Hildingh et al., 2007) revealed that recovery was experienced as a complex process in terms of having to cope with balancing the focus of their daily life between looking after themselves and/or towards other people.

Due to the androcentric nature of research, women are often viewed as one large homogenous group (Cosgrove, 2003). Nonetheless, the reality is much more complex, where

women's experiences are multiplex, broad and diverse and are shaped by social, cultural, religious, and economic contexts. Reflecting this diversity, Crenshaw (1989) developed the concept of intersectionality as a critique to the mainstream (white) feminist approach that frequently ignored the experience of poor black women, while foregrounding the gendered experiences of white intellectual women. In the field of CVD research, there has been an increasing trend towards focusing on women. However, the majority of the studies were mainly focused on the experience of the women in high-income countries; thereby excluding large populations of minority and ethnic groups.

The exclusion of women from those minority and ethnics groups in CVD research (McCormick & Bunting, 2002) has resulted in findings that generalize women's experiences; consequently, the experiences of many women from minority and ethnics groups have not been adequately addressed. While many similar topics have been the focus of research in high-income contexts, no previous study was found that focused on understanding the experiences of women with heart disease in Indonesia. This exploration is important because the social construction of womanhood in Indonesia has been strongly influenced by the blend of state ideology, Javanese cultural traditions, and Islamic norms (Ida, 2001). Almost 90% of Indonesia's total population is Muslim, making it the largest Muslim majority country in the world. Research about CVD and CVD management in Indonesia has heavily emphasized biomedical aspects of the disease; as a result of this orientation little is known about how people experience the disease at the individual level, especially women with CVD (Maharani & Tampubolon, 2014; Schröders et al., 2017). Scholars suggest that explorations of day-to-day illness experiences among people from different socio-cultural backgrounds are essential to provide opportunities for an in-depth understanding of a broad range of contextual factors that influence how people live when affected by a chronic disease (Lawton, 2003).

1.1. Study aim

The aim of this study was to understand how their gender shapes the experiences of Indonesian women with heart disease and, in particular, how the condition affects their personal lives. The focus of the present study was on ischemic/coronary heart disease and other heart problems such as valvular issues.

2. Methods

2.1. Design

In exploring women's experiences, this research study used qualitative research, which was underpinned by feminist sensibilities. The experiences of the participants were placed at the center of the research, with a particular focus on understanding the ways that gender shaped their experiences of CVD. In 'giving voice' to the women (Ramazanoglu & Holland, 2002) who participated in this research, this 'voicing' served as a form of empowerment. While this study used qualitative data collection methodology; the analysis, interpretation, discussion, and recommendations were informed by an intersectional approach to gender and culture. In considering the cultural and gendered approaches to research, reflective activities were considered as an integral part of the interpretative process in this study.

2.2. Participants and setting

This study was conducted in an outpatient cardiac rehabilitation (CR) center of the National Cardiovascular Center (NCC), Harapan Kita Hospital, Jakarta, Indonesia. A total of 26 women participated in the research. The participants were selected using a purposive sampling strategy. The inclusion criteria were: 1) women who were over 18, and 2) had experience of cardiac events. Participant's diagnosis included a wide range of different cardiac

conditions, such as MI and congenital issues (atrial and ventricular septal defect and tetralogy of Fallot). The participants were approached by CR nurses who were acting as the study's gatekeepers. At this stage an information package including: a) the participant information sheet, b) an invitation to participate, and c) the consent form was provided to potential participants. Out of the 31 potential participants who were approached, 26 agreed to take part in the study. The five participants who declined to participate were those who decided to not enroll in, or who dropped out of, the phase two CR program. Data was considered saturated when no new codes / information emerged from the data. However, two additional participants were recruited in order to ensure data saturation was achieved. The participants had not met any of the researchers prior to the beginning of the study.

2.3. Data collection

The first author (SS), an Indonesian nurse academic conducted in-depth interviews between June and September 2016, using a semi-structured interview guide, during the 2-6 weeks following the participant's hospital discharge. Twenty-three interviews were carried out in the outpatient CR unit, and three interviews were conducted by telephone at a date and time which were entirely the participant's choice. The duration of the interviews ranged from between 15 and 75 minutes. Before the actual data collection, the interview guide (see Table 1) was pilot tested with two women to check the clarity of the questions. Open-ended questions were used to allow participants to answer in their own words and offer their personal opinions, views, and experiences. All interviews were conducted in the Indonesian language. Interviews were audio-recorded and subsequently transcribed verbatim by SS. Following that, each transcript was checked for errors by listening to the audio-recordings of the interviews, while simultaneously reading the transcript. Field notes were written soon after the interview to capture the contextual details.

In this study, we considered the women as experts regarding their experiences of heart disease. We also incorporated a collaborative relationship with the participants by using a more conversational and sharing approach when conducting their interviews (Oakley, 1981).

2.4. Data analysis

The data analysis involved a data-driven inductive approach by using framework analysis (Gale et al., 2013; Ritchie & Spencer, 1994). The steps of the framework analysis approach, outlined by Ritchie et al. (2014), were as follows: 1) familiarization with the data; 2) developing an initial thematic framework; 3) indexing the data (i.e., the initial thematic framework was applied to the data, labeling sections of text using the existing categories and codes); 4) charting (data summary and display, using a framework matrix); and 5) abstraction and interpretation. During the familiarization process, all authors independently read and re-read five interview transcripts that were translated into English by SS. To ensure that there were no changes in meaning during the translation process, back-translation from English to Indonesian was also carried out. Following this procedure, an initial thematic framework based on the emerging issues arising from familiarization was developed. The research team held regular meetings to discuss and review this initial thematic framework until consensus was reached. This initial thematic framework, consisting of categories and codes, was then applied to the remaining transcripts by SS. Once all data has been coded, the data were summarized and arranged into thematic matrices. The next step of the data analysis was data abstraction and interpretation, in which the participants' accounts were compared to find similarities and differences. Simultaneously, we incorporated the perspective of intersectionality by continually asking how each individual account was related to the broader social, cultural, and religious structures of the dominant Indonesian context.

2.5. Rigor

Rigor or trustworthiness was achieved through credibility, transferability, dependability, and confirmability, as suggested by Lincoln and Guba (1985). To ensure credibility, the researchers implemented strategies, such as prolonged engagement with participants and informal member-checking (i.e., through deliberate probing and summarizing or repeating previous information back to participants). The participants were offered an opportunity to review their interview transcript, but we were not able to contact the participants with the final findings as the main researcher had to return to the UK following data collection. As a result it was not practically possible to then contact the original participants. In terms of transferability, details of the research setting, methods, participants, as well as the theoretical assumptions underpinning the study were provided. To enhance dependability, NVivo 11 was used to store and manage the data to facilitate the audit trail. Lastly, to enhance confirmability, the procedure for checking and rechecking the data throughout the study was documented.

2.6. Ethical considerations

The research ethics committee at the University of Edinburgh, Scotland and the local Indonesian hospital (No: LB.02.01/II/0859/2016) approved the study. Informed consent was sought from the participants who agreed to participate in the study prior to their interviews after they received, read and were comfortable with the written and verbal information. The participants were also assured that they could withdraw from the study at any time without any consequence and without being required to give any reason.

3. Results

A total of 26 Indonesian women who had undergone cardiac surgery participated in this study. Details of the participants interviewed are outlined in Table 2. Participants' narratives about their illness-linked experiences were all strongly influenced by their social, cultural and religious values and traditions. The following three main themes were identified from the data analysis: 1) the effect of CVD on the women's day-to-day activities, 2) the effect of CVD on the women's family relationships, and 3) the women's coping strategy. What is particularly interesting in the Indonesian context is that these themes were all underpinned by the gendered concept of 'maintaining harmony', which is socially constructed as a woman's responsibility in Indonesian society.

3.1. Effect of CVD on women's day-to-day activities: loss of control

All the women in this study identified a lack of autonomy and control as the most significant impact of the physical impairment and functional limitations associated with cardio-vascular disease. Heart disease had a significant impact on their ability to carry out normalized roles as a mother, a wife, and a member of society, which are elevated in Indonesian society as the most important roles of a woman, and which are perceived as essential in maintaining harmony in Indonesian society.

3.1.1 Housework: *"everything has changed"*

Consistently, the women in this study stated that *"everything has changed"* since they experienced their heart disease. The inability to carry out domestic tasks caused the women to feel 'profound guilt'. They felt this way because the participants considered housework as solely their responsibility. In a society where women are expected to maintain and manage the domestic sphere, in order to also ensure social harmony, these situations created uncomfortable feelings for the 26 women. This resulted in them feeling less useful than before their heart

disease or, as some of the participants said, *"useless"*. One woman described her feelings as follows:

> *"...I feel troubled because I can't do the housework. [...] My son helped to sweep the floor, but you know, 'a man is a man', right? Indeed, he swept the floor, but 'just like that'. So yeah, it troubled me a lot because I cannot do it on my own". (P3)*

3.1.2 Social withdrawal

Some participants in the study described that when their symptoms became worse, they had to withdraw from participating in social activities. One participant described how she had been actively involved in several social activities in her village; however, after she was diagnosed with CVD she was no longer able to participate. In Indonesia, the gendered role of women is entwined in hosting social activities, and if this is curtailed, then the women felt a loss of purpose and role. She explained:

> *"I used to be an activist. I participated in many social activities [...] Everything has changed since I suffered from heart disease. [...] It feels weird you know, because of my illness, well, maybe Allah is testing me..." (P8)*

3.1.3 Giving up job/employment

Some of the women in this study used to be full-time workers, but they had to voluntarily give up their job due to their illness. One participant, who acted as the primary earner in the family, stated that she felt troubled giving up her job. She experienced a conflict between providing care for others and providing care for herself in day-to-day life. She felt guilty about not doing enough for her family, even though she had a condition that also required care. This participant's account illustrates how the women tended to place others' needs before

their own to maintain social harmony. In preserving harmony within the Indonesian context, women are required to submit, keep quiet, and make sacrifices for the family.

3.2. Effect on women's family relationships

Suffering from CVD not only challenged the women at the individual level but also at the familial and social levels. Over and above their illness, women in this study were aware of the expected roles they must perform to maintain harmonious interactions with their family and the members of their communities. Women are continually expected to engage in activities directed at maintaining good relations. For these reasons, rather than focusing on their own needs, the participants emphasized the requirement to consider other people's feelings and needs.

3.2.1. Changing relationship patterns: from a caregiver to a care receiver

Many women portrayed themselves as self-reliant, as well as socially and physically active. Prior to their CVD diagnosis they had occupied a central role in the family as the key caregivers instead of, as now, care receivers. Due to their illness the women were no longer able to perform their normal functions and roles, a perceived demotion that posed a stress-inducing threat to their identity and contributed to their feeling of being a 'failure'. One participant stated:

> *"I feel like I am burdening my family a lot. I feel pity for them. I should be able to help my parents or my husband. On the contrary, my husband is the one who always helps to take care of me. I am so grateful that he doesn't complain at all." (P17)*

3.2.2. Separation

Most women with young children had to leave their children to be supervised by others due to their mothers' degenerating physical condition that required the women to focus on their treatment. The patients asked their parents or relatives to look after their children during their treatment period. One participant described her experience:

> *"I was separated from my kids when the small one was only eight months, so I wasn't able to breastfeed her anymore, right? It's been around a year I haven't met my daughter. […] She's been taken care of by my parent-in-law..." (P18)*

Concurring with international studies (Angus, 2001; Finn, 2001), for the participants in this study, the role of caregivers for children was most important. Thus the younger women, with relatively young children, found it very hard to accept their diagnosis and condition. For this reason, participants also expressed feelings of guilt about not being able to look after their children properly, since they could not fulfill their roles as a 'good mother'.

3.2.3. Marital conflicts

Although most participants described that they received a great deal of support from their spouses, children, or extended family members, some participants revealed information suggesting disrupted relationships, such as marital conflict, or communication issues with family members. In a country like Indonesia, where divorce is viewed as a deeply humiliating event (*aib),* it is often associated with personal dishonor (Mahy et al., 2016; Parker & Creese, 2016); and therefore particularly shameful. One participant explained that since being diagnosed with congenital heart disease, she experienced conflicts with her (now ex) husband. She described:

> *"...he cheated on me, and now he is married to another woman. From 2008 to 2014, he just didn't care when my illness relapsed many times. He said I just dramatized the situation. So yeah, finally, I asked for a divorce." (P20)*

3.2.4. Overprotective family

The women frequently described that the reduced freedom and independence were not a mere consequence of their illness, but also came from their families that tended to be overprotective. In Indonesian society, where a mother plays a central role as the caretaker and housekeeper of the family (Ronen, 2016), performing domestic roles (as cited above) is constructed as a mother's primary duty. Therefore, it was perceived as inappropriate to pass those responsibilities to others. One woman described her frustration when her husband told her to stop her usual task of cleaning the house when she thought she was still able to manage it. She explained:

> *"They get mad at me if I did it… "Later, you can do it, but not now," for God's sake, it was only sweeping the floor… I could not just sit down all day doing nothing […] I think it's okay as long as I don't lift heavy stuff…" (P10)*

3.3. Women's coping strategies: maintaining harmony

As the participants identified themselves as the family's leading caregiver, their cardiac conditions challenged the established roles and norms in the family; hence, it was quite likely that the family harmony could no longer be sustained. Maintaining harmony in Indonesian culture is a very strong gendered value ascribed to women, because family harmony is seen as synonymous with social harmony in the wider sense. In this study, women's strategies to maintain harmony in the family included: *"I just can't sit around and do nothing!"* and *"I keep it secret!"* This finding highlighted both the social pressure the women felt to maintain harmony and also the shame associated with not being able to carry out these societal and cultural gendered roles, as expected of them.

3.3.1. "I just can't sit around and do nothing!"

All the women in this study, despite difficulties, tried to maintain their normal roles to protect their families from being overly concerned about their condition. They viewed housekeeping duties as something that they were used to doing and which brought a feeling of normality. A common theme that heard from the women in this study was: "*I just can't sit around and do nothing"*. From the participants' narrative, it was important for them to show that they still had the strength and energy to perform their gender-specific roles as mothers. One woman decided not to ask for help and managed the household tasks and childcare duties independently, despite her worsening symptoms. She expressed that it was not good or convenient to be dependent on other people or to impose burdens on her family. She commented:

> *"…and ever since they were babies, we never asked our parents to help us with the kids. We did everything on our own, so it was only recently, because my condition got worse and I had to go for some intensive treatment, I asked my parents to help us with childcare." (P8)*

3.3.2. "I'll keep it a secret!"

Participants perceived the heart as the center of their life. Therefore, revealing their cardiac condition to their family members would make family members very anxious. The women were concerned that their symptoms would interfere with household duties and caring for others. Revealing the illness to the family would also significantly disrupt family harmony, the management of which was socially ascribed to the role of women. Being unable to maintain this harmony brought a deep sense of shame. One woman stated:

> *"When my husband asked what's wrong with me, I told him that maybe my cholesterol was high. […] I didn't want him to worry about me. Because the*

heart is the center of our lives. If he knew it, I was afraid that it would become a burden to him" (P16)

4. Discussion

This study has uncovered how culture and gender shape women's experience of heart disease in Indonesia and how it negatively affected their personal lives. The findings demonstrated that heart disease created functional limitations for the women and, more importantly, had a significant effect on their sense of self and their expected role in society. Heart disease had altered their daily lives and their female identity in unacceptable ways; specifically, their internalized norms and perceptions about what it is to be an ideal woman in their Indonesian context (Bird & Rieker, 1999). The women felt that heart disease intertwined with, and altered the gendered expectations, relating to their ability to care for others; an ability and role they perceived as central to their identity as a woman in Indonesia. At the same time, as cardiac patients they were aware of the limitations imposed on them by the disease. For some of the women their very limited ability to carry out normal roles as a mother/wife meant they were no longer able to fulfill cultural and gendered expectations. These expectations extended beyond doing the household chores and caring for the family as they were wrapped up in the social and gendered expectations of maintaining harmony within the home and wider Indonesian society. These limitations caused the women to feel they were a burden to their families; a perception which threatened their sense of self. In Indonesian society, which emphasizes social harmony and group solidarity, the feeling of being a burden to others contradicts the ideal characteristic of a 'good woman', and undermines the traditional feminine role of the family caregiver in Indonesian society.

The interviewees reported that since experiencing heart disease, they were 'unable to do anything like before' in the sense of performing domestic duties and caring for the family,

including the gendered role of wife and mother. This finding concurs with several other studies from both Western (Pihl et al., 2011) and Asian (Seah et al., 2016) perspectives. These studies reported that reduced physical ability resulting from heart disease often created various restrictions on many aspects of the individuals' lives. Being unable to fulfill their previous social roles, as wives or mothers, caused the participants to experience psychological discomfort and stress. Hildingh et al. (2007) suggested that women experience a greater sense of loss and frustration resulting from a CVD diagnosis than that experienced by males, due to women's greater domestic roles in their normal situations.

Most of the women in this study explained situations related to a sense of social displacement, in which heart disease had prevented their full engagement in activities connected with their former domestic and family-centered identities. The participants were concerned about losing standing in front of others if they could not maintain harmony in the home. A woman's status would be lost or significantly reduced if she failed to live up to social and cultural expectations. Dalal and Biswas (2009) assert that an individual being unable to provide support to family and friends can relatively quickly lead to an erosion of that person's self-worth. This is particularly so in Indonesian society, where the social and cultural harmony of society is constructed and maintained by women performing gender- specific, culturally-traditional roles as described above.

Maintaining familial and societal harmony was noted as the most important finding in this study relating to Indonesian women's roles. The women interviewed demonstrated the continuous efforts to maintain their gendered roles of wife and mother to protect their families from being overly concerned about their condition, so that harmony in the family would be sustained. Maintaining harmony in the family has been recognized as an extremely important responsibility for a woman within Indonesian society (Sitepu, 2000). These findings align with the previous study on Javanese people's perception of CVD from (Dewi et al., 2010), who also

found that balance and harmony are central to the participants' understandings about ways of managing CVD. Santillan et al. (2002) stated maintaining a harmonious home environment typically requires women to do all the housework. Townsend (2000) echoed this view by stating that women's primary responsibility is to create a feeling of order and security within the home. In preserving harmony within the Indonesian context, women are required to submit, keep quiet, and make sacrifices for the family (Geertz, 1989).

The emphasis that women in this study placed on their roles as wives and mothers also concurs with another study, whereby the authors found that women presented themselves as a 'good housewife' despite their pain, in order to maintain a positive identity; an image reinforced by continuing to perform their traditional gender roles (Richardson, 2005). Although performing household tasks aggravated their health condition, the women in this present study stated that it also helped improve their sense of usefulness. This finding is also similar to the research by Baker et al. (2016), who reported that being able to perform previous routines became an important aspect of maintaining normality or continuity from the past. In an Indonesian cultural context, this ability is particularly important because of the task of maintaining harmony and social relationships between family and society represents an important part of their domestic duties. Consequently, when there is a disruption in the family harmony, it would be seen and understood as the women's failure to protect 'her' family.

This research indicated that the female participants preferred to hide their CVD illness from their families. This finding concurs with other Western research which reported women deliberately hid their illness, particularly if: 1) the symptoms interfered with household duties and caring for others (Currie & Wiesenberg, 2003; Galick et al., 2015) or 2) if they assumed they would become a burden to their family (Davidson et al., 2008; Medved & Brockmeier, 2011).

Implication for nursing practice

This study offers a deeper understanding of Indonesian women's experiences of living with heart disease. The findings of this study provide health professionals, service providers, and policymakers with broad insights into common elements of Indonesian women's experiences of heart disease and potential options for improving their health and wellbeing. Thus, the findings can enhance the implementation of patient-centered care as well as collaborative approaches in Asian contexts. Cardiac nurses and other healthcare professionals should have intercultural competence skills, to enable them to deliver services that meet the social, spiritual, and cultural needs of their patients. Healthcare professionals should be aware of the ethnic and cultural backgrounds of their patients so that: 1) they would be able to determine the different behaviors of the patients with CVD; and, 2) could provide appropriate care for those patients.

Limitations

Since this study was only conducted in one single setting in Indonesia, the experience of the women in this study might not reflect a larger Indonesia perspective. For this reason, we must be cautious with any attempts at generalizing the findings of this study. However, the research team made an effort to contextualize the results so that that the reader can evaluate to what extent our results might be applicable to other settings. Another limitation of this study lies in the fact that only women who had undergone cardiac surgery participated in this study. Therefore, the experiences of the women in this study might be different from the women whose heart disease is medically and/or differently managed.

5. Conclusion

The Indonesian women in this study developed strategies to protect their social dignity and to maintain harmony within the family and society while also dealing with their current CVD condition. They were continuously re-negotiating and adjusting the assumptions and social constructs of good mothering, in order to facilitate both their mothering role and their sense of self-esteem. In line with other similar international studies, the women in this study defined themselves by the social roles they performed within Indonesian society, such as a mother, a wife or both. Nonetheless, for Indonesian women participants there are gender-specific roles particular to Indonesian culture, which clearly relate to 'maintaining harmony'. These roles were major influences regarding their responses to living with CVD and in 'shaping self'. Further research should be carried out to investigate how cultural and spiritual values affect women's recovery rates from heart disease. Moreover, future research that compares men's and women's experiences to investigate: a) how gender interplays with ethnic or religious backgrounds; and b) how masculinity and femininity influence illness experiences should also be conducted.

Authors' contributions

Study design: SS, FC, AH

Data collection: SS

Data analysis: SS, FC, AH

Manuscript writing and revisions for important intellectual content: SS, FC, AH

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List of tables

Table 1. Interview questions

No	Question
1	*Could you describe the events that led up to your admission to the hospital?*
2	*What was going on in your life after knowing that you suffered from heart disease?*
3	*What changes (positive and negative) have occurred in your life since experiencing heart disease?*
4	*How was your typical day before and after you were diagnosed with heart disease?*
5	*How do you describe the person you are now?*
6	*What helps to cope with your condition?*
7	*How have you changed as a person since experiencing heart disease?*

Table 2. Participants' characteristics

No	Age	Ethnicity	Marital status	Occupation Status	Religion	Diagnosis*
1	44	Sundanese	Married	Full-time	Islam	MR severe
2	41	Sundanese	Married	Part-time	Islam	MR severe
3	66	Batak	Widowed	Part-time	Christian	MI
4	62	Betawi	Widowed	Part-time	Islam	MI
5	32	Betawi	Divorced	Unemployed	Islam	MI
6	44	Javanese	Married	Unemployed	Islam	MR severe
7	43	Sundanese	Married	Full-time	Islam	MR severe
8	36	Minahasan	Married	Unemployed	Christian	Aortic stenosis
9	54	Javanese	Widowed	Unemployed	Christian	MI
10	44	South Sumatra	Married	Unemployed	Islam	MR severe
11	33	Javanese	Married	Unemployed	Islam	MR severe
12	61	Minangkabau	Widowed	Retired	Islam	MI
13	58	West Nusa Tenggara	Widowed	Part-time	Christian	MR severe
14	53	Javanese	Married	Full-time	Islam	MI
15	36	East Nusa Tenggara	Married	Unemployed	Christian	MR severe
16	42	Batak	Married	Part-time	Christian	Tetralogy of Fallot
17	36	Sundanese	Married	Unemployed	Islam	MI
18	30	Javanese	Married	Unemployed	Islam	MR severe
19	30	Javanese	Married	Unemployed	Islam	MR severe
20	36	Javanese	Married	Full-time	Islam	ASD
21	58	Minangkabau	Married	Part-time	Islam	MI
22	46	Banjarese	Married	Part-time	Christian	ASD
23	55	South Sumatra	Married	Full-time	Islam	MR moderate
24	58	Minangkabau	Married	Unemployed	Islam	ASD
25	55	South Sumatra	Married	Full-time	Islam	MR moderate
26	49	Javanese	Married	Unemployed	Christian	MI

*MR = Mitral Regurgitation; MI = Myocardial infarction; ASD = Atrial Septal Defect